

## Counselling

# One-to-one counselling for STI prevention: not so much whether as how

Helen Ward

The UK National Institute for Health and Clinical Excellence is about to recommend prevention counselling to reduce STI risk. A US paper in this issue reviews relevant evidence and looks at the challenges for implementation in busy clinics.

Few people would disagree with Geoffrey Rose's justification for disease prevention: "It is better to be healthy than ill or dead".<sup>1</sup> In the field of sexually transmitted infections (STI) and HIV, preventive interventions have gone alongside treatment and care for as long as services have existed, but the priority given to each has varied over time.

In this issue (*see page 2*), Cornelis Rietmeijer reviews risk reduction counselling for STI, questioning the lack of implementation of interventions of proven efficacy.<sup>2</sup> He looks particularly at the USA, where the Centers for Disease Control and Prevention (CDC) have advocated risk reduction counselling in relation to HIV testing services, but this has not always been carried out in practice.

Rietmeijer includes evidence in his review showing that in Project RESPECT, two brief one-to-one counselling sessions resulted in a 30% reduction in STI incidence at six months. In subanalyses there was a 47% reduction in men and women under the age of 21 years, with nine STIs prevented per 100 people counselled.<sup>2</sup> The characteristics of effective counselling include that it be based on the personal risk of the individual rather than predetermined standard messages, and that it use one or more theoretical approaches to behaviour change. Further studies have shown that a single counselling session, for example in the context of rapid HIV testing, may be as effective as the two-step intervention of Project RESPECT. Rietmeijer therefore states: "The question currently facing STI service providers is therefore not so much whether counselling should be part of the standard of STI care but rather how this intervention can be implemented given the logistical and resource constraints of a busy practice setting."<sup>2</sup>

This is exactly what clinicians in the UK will be asking themselves in coming

months, as the UK National Institute for Health and Clinical Excellence (NICE) issues its own public health guidance on interventions for the prevention of STI and under-18 conceptions in February.<sup>3</sup> At the time of going to press the guidance had not been finalised, but is likely to include a recommendation for one-to-one counselling. The draft, published in October 2006, stated that health professionals in various settings (including genitourinary medicine (GUM), community contraceptive clinics, abortion services, primary care and elsewhere) should identify and "provide counselling for individuals at high risk of STI. The counselling should comprise one-to-one structured sessions. The number of sessions will depend on individual need, but each should last 15–20 minutes".<sup>3</sup>

The recommendation is based on a review of evidence similar to that presented by Rietmeijer, and, just as in the US, the challenge is no longer whether but how.

Modernisation of sexual health services in the UK, driven by the attempt to reduce waiting times with a minimal increase in resources, has involved a move away from long and repeated consultations towards a streamlined approach with rapid testing, single visits and, in some cases, self-completed sexual histories and self-collected specimens.

This can all add up to a service involving very little contact with a healthcare professional. It will therefore be a major challenge to add one or two 20-minute counselling sessions into this type of service. The recommended counselling should ideally be offered to most patients as almost all patients attending GUM—and many attending community contraceptive and primary care services—will be identified as at-risk according to NICE.

The draft NICE guidance included the following definition: "High risk groups

include anyone with—or being tested for—an STI/HIV, men who have unsafe sex with men, substance mis-users, sexually active young people and anyone with multiple sex partners." This is likely to be modified in the final guidance to include men who have sex with men, alcohol and substance mis-users, people reporting unprotected sex and frequent change of and/or multiple sexual partners, together with people who come from, or who have visited, areas of high HIV prevalence.

This still amounts to a high proportion of the workload of GUM clinics, and we will be expected to find ways of offering such counselling. Rietmeijer is fully aware of these challenges, which he also faces daily in his busy public health clinic in Denver, and includes some practical suggestions. He argues that rather than seeing prevention counselling as a time-consuming add-on, it could be embedded into the basic history, using a client-centred risk assessment rather than the use of closed questions to complete a patient proforma. He argues that this could then be "the stepping stone towards a risk reduction plan". He points to developments in computing that could deliver some interventions online.

The publication of the NICE guidance, while a great challenge, is also an opportunity for specialists in sexual health to develop new ways of improving prevention. We welcome contributions to *STI* on this topic, and on the rest of the NICE guidance, and look forward to a lively debate. Perhaps we can then help shift the balance further towards the healthy than the sick or dead.

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## REFERENCES

- 1 Rose G. *The strategy of preventive medicine*. Oxford: Oxford Medical Publications, 1992:4.
- 2 Rietmeijer CA. Risk reduction counselling for prevention of sexually transmitted infections: how it works and how to make it work. *Sex Transm Infect* 2007;**83**:2–9.
- 3 National Institute for Health and Clinical Excellence (NICE). Public Health Intervention Guidance: One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups. 2007 (draft). Available at <http://www.nice.org.uk/page.aspx?o=SexualHealthMain>.